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Medical and Health Service Support Activities deploys with Marine Air Ground Task Force

Filed under CORPSMAN, FLEET AND THE FLEET MARINE FORCE, FORCE HEALTH AND SAFETY [NO COMMENTS]

By Capt. Harold Groff, Force Surgeon for Special Purpose Marine Air Ground Task Force, Crisis Response-Central Command

Editors Note: Capt. Harold Groff, has served in the Navy for 30 years. First as a Civil Engineer Corps officer for more than 10 years before changing careers and going back in rank as an ensign to attend USUHS from 1996 to 2000. He recently returned from deployment with Special Purpose Marine Air Ground Task Force (SP MAGTF) that began the middle of September 2014. The concept of deploying SP MAGTF for Crisis Response was in response to the lack of capability during the events at Bengazi.

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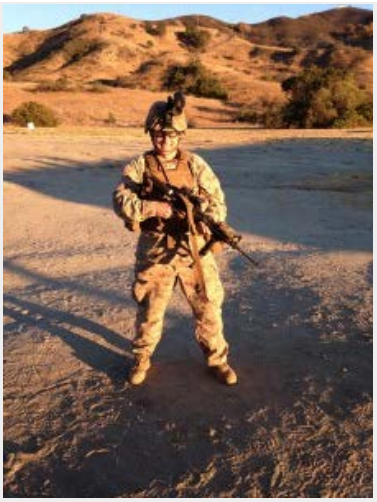

Training at Camp Pendleton, prior to deployment. Our first opportunity to come together was at the Mission Readiness Exercise (MRX) in El Centro, California, in August 2014.

The Special Purpose Marine Air Ground Task Force Crisis Response Central Command (SPMAGTF-CR-CC) was formed from several different units at divergent locations in the southwestern United States (from four home stations in California and Arizona with some specific enablers from throughout the USA).

We rapidly came together to form a cohesive team, which included 5 physicians, 11 providers and 102 total medical personnel with the mission to care for over 2,600 Marines and Sailors throughout the Middle East.

The training we received proved to be quite valuable as we were called to execute these functions in support of Operation Inherent Resolve (OIR).

We had to establish the initial table of equipment to support five units in five countries. This ended up requiring the deployment of 22 Authorized Medical Allowance List allotments, which almost cleaned out the reserve supply of the 1st Marine Expeditionary Force.

Our first opportunity to come together was at the Mission Readiness Exercise (MRX) in El Centro, California, in August 2014. Under expeditionary conditions, we were able to evaluate several medical capabilities including the employment of personnel on the MV-22 Osprey for Tactical Recovery of Aircraft and Personnel (TRAP) and Humanitarian Assistance/Disaster

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Relief (HA/DR) missions. This training later proved to be quite valuable as we were called to execute these functions in support of Operation Inherent Resolve (OIR).

As soon as we arrived in theater, we discovered that our operational mission tasking would be dynamic. Almost immediately, our Aviation Command Element was involved in performing airstrikes in support of OIR. Our headquarters moved to a base that had not been occupied for three years. This involved a significant amount of cleaning and repairs to existing facilities to make them suitable for the provision of medical care. Complicating this action, within two weeks of arrival, coalition partners began to arrive in support of OIR.

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An additional complication that we soon discovered was that when you bring groups of different people from different parts of the world and put them together in a close environment, the risk of spreading infectious disease increases. Within two weeks of the arrival of the coalition partners, we had an outbreak of gastrointestinal illness, which eventually involved 60 patients. A few of these patients were ill enough that they required evacuation to the nearest hospital with symptoms such as fever greater than 103 Fahrenheit and severe headaches and meningismus. Advanced diagnostics demonstrated that this outbreak was due to Norovirus. Hygienic measures were implemented on the base which controlled the outbreak.

The dynamic operational taskings continued, as within the first month we were tasked with providing a marine security detachment to a forward US Embassy. We also assumed operational control for another squadron of aircraft, the EA6B aircraft from VMAQ-4, from a neighboring country assigned to our command. This meant that we were also responsible for their provision of medical care.

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Starting in October and over the next two months, we received mission taskings to assist the Special Operating Forces (SOF) and to perform site surveys for potential Build Partner Capacity (BPC) sites in Iraq. Soon thereafter, SPMAGTF was tasked to initiate and support one of the BPC sites. Because of the distance of the site from the nearest receiving hospital that could provide surgical care, a Forward Surgical Team (FST) was assigned to provide the capability for damage control surgery as an enhancement to the SPMAGTF-CR-CC Role One medical facility at the site. Due to the lack of any local national surgical or emergency medical capacity, SPMAGTF-CR-CC medical personnel worked hand-in-hand with the Army's 67th FST to provide life and limb saving surgery to over 45 for local national soldiers and civilians.

One of our initial tasking sites was to provide a Marine security force for the protection of the U.S. Embassy in Yemen. Due to the deteriorating security situation in that country, the decision was made to depart from the embassy. Through the diligence of the Marines and the careful attention to medical issues by SPMAGTF-CR-CC medical personnel, there were no injuries or illnesses during this departure.

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We also served in a mission to provide training through Theater Security Cooperation with the local army in another Middle Eastern country, the seventh location where we supported a Role One facility. Shortly before the time that we were due to return from deployment, a group of reservists redeployed from this site and were then re-mobilized. As a part of this process required PPD testing was performed. When it was discovered that three out of the 19 Marines and Sailors had positive tests, an investigation was commenced to evaluate the risk and to rule out that there were cases of active tuberculosis among the Marines and sailors from SP MAGTF.

The screening was accomplished in an efficient manner over a 96 hour period and demonstrated no concerning cases. This action minimized the risk to others during the plane flights and redeployment home, as well as a potential risk to family members at home. At the time of our deployment, the Centers for Disease Control (CDC) considered Jordan to be a low risk country for the transmission of tuberculosis. However, given that our Marines and Sailors were working in close contact with local nationals for greater than one month and the fact that there had been an influx of as many as 500,000 refugees to that country over the past year, which included areas in close proximity to our camp, it was not clear that this

estimate of low risk was still current.

We rapidly came together to form a cohesive team. Our office in Kuwait. Back row L to R HMCS Austin Ivy and Lt. Cmdr. John H. Jones. Front row L to R: HM2 Nicholas Ullrich, Capt. Harold Groff and PS2 Gilberto Infante. As you can see we all shaved our heads during the deployment.

In summary, it was a pleasure for Navy medical personnel to play a key role in the successful deployment of the first SPMAGTF-CR-CC by establishing an effective health services support system spread over six countries in the Middle East, which played an important role in the successful execution of all SPMAGTF-CR-CC missions, despite a highly dynamic operational environment.

Joint Training Center in Jordan. Lt. Vlad Stanila, our aviation combat element flight surgeon is also in the photo. At the time of our deployment, the Centers for Disease Control (CDC) considered Jordan to be a low risk country for the transmission of tuberculosis.

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